

REFERRAL TO: Northwest Hospital Sleep Center

FAX TO: (206) 215-1135

Date: _____

Patient Name: (First, Middle Initial, Last): _____

Patient DOB: _____

Patient Daytime Phone: _____

Patient Evening Phone: _____

Patient Primary Insurance Carrier: _____

Referral To (choose one):

Sarah Stolz, MD

Barbara Parkman, MN, ARNP

Ian Merrill, MD

Next Available Provider

Lina Fine, MD

Pediatric Sleep Medicine: Preetam Bandla, MD

Appointment:

Next Available

Urgent within _____ days

Evaluation Request For (choose as many as apply):

Snoring

Sleep Apnea/Sleep-Disordered Breathing

Insomnia

Unexplained Fatigue

Daytime Sleepiness

Narcolepsy

Night Terrors

Shift-Work/Jet Lag

Restless Legs Syndrome

Apnea Link Screening (If Positive, Consult)

Parasomnias

Other

Referring Provider Name (please print): _____

Provider Clinic Facility Name: _____

Provider Phone: _____

Fax: _____

Address: _____

City/State/Zip: _____

Additional Reports To: _____

Additional Comments: _____
